No. 09-1183

In The Supreme Court of the United States

LITTLE ROCK CARDIOLOGY CLINIC, P.A., ET AL.,

Petitioners,

v.

BAPTIST HEALTH, ET AL.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF IN OPPOSITION FOR RESPONDENTS BAPTIST HEALTH AND BAPTIST MEDICAL SYSTEM HMO, INC.

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QUESTIONS PRESENTED

Whether, because petitioners failed to raise the issue before the district court and Eighth Circuit, they have waived their argument that the Eighth Circuit erroneously required them to allege a relevant market.

Whether, when the claims of antitrust injury, competitive harm, and damages in petitioners' complaint were based on their foreclosure from the ability to compete for privately insured patients and the complaint alleges that they provide services to publicly insured patients as well as privately insured patients, a relevant product market limited to privately insured patients is plausible.

Whether, when the definition of the relevant geographic market for health-care services in petitioners' complaint was based on patient-flow data, allegations that few residents of an area leave that area for services are sufficient to plausibly show that the area constitutes a relevant geographic market.

CORPORATE DISCLOSURE STATEMENT

Respondent Baptist Health is an Arkansas non-profit corporation. It has no parent or stock. The parent company of respondent Baptist Medical System HMO, Inc., is Multi-Management Services, Inc., a wholly owned subsidiary of Baptist Health. No publicly held company owns ten percent or more of the stock of Baptist Medical System HMO, Inc.

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INTRODUCTION

Petitioners seek review of the Eighth Circuit's decision affirming dismissal of their third amended complaint (the Complaint), which attempted to allege violations of Sections 1 and 2 of the Sherman Act but failed to allege a plausible relevant product market or relevant geographic market. Nothing about this case warrants this Court's attention.

1. Although Petitioners now argue that they were not required to define a relevant market, they conceded below that definition of the relevant market is essential to all their claims.

2. The Complaint alleges a relevant product market limited to services provided to privately insured patients, resting entirely on allegations that private health insurance and public health insurance (Medicare and Medicaid) are not reasonably interchangeable from the perspective of cardiology *patients*. The lower courts assumed that those allegations were true, but concluded that they were largely irrelevant, given the nature of petitioners' claims. The Complaint asserts antitrust claims arising from alleged competitive injury to the plaintiff *cardiologists* resulting from their exclusion or foreclosure from patients. For those claims, the critical question for purposes of market definition is whether patients covered by private insurance and patients covered by public insurance are (or are not) reasonably interchangeable from the perspective of *cardiologists*, not whether private and public insurance are (or are not) reasonably

interchangeable from the perspective of *patients*. As to the former issue – the determinative issue – the Complaint alleges no facts at all.

3. The Complaint alleges a relevant geographic market limited to Little Rock and North Little Rock, Arkansas (Little Rock). But the only facts alleged to support that geographic market concerned the percentage of cardiology patients residing in Little Rock who obtain treatment from providers located in Little Rock. The lower courts assumed that those allegations were true, but concluded that they were insufficient to plausibly support the alleged geographic market. The Complaint alleges that providers in Little Rock draw a large percentage of patients from throughout the state, but it contains no allegations that providers in other areas and those in Little Rock are not reasonably interchangeable from the perspective of patients residing outside of Little Rock. Absent these allegations, the facts that are alleged are insufficient to support the proffered geographic-market definition.

4. Applying well-established antitrust principles, the Eighth Circuit affirmed the district court's judgment that the Complaint failed to allege facts crucial to market definition and petitioners' claims. That decision, which addressed only the factual allegations of *this* Complaint, was correct and is consistent with decisions of the other courts of appeals considering the same issues. Nothing in the decision will impair legitimate antitrust claims in the health-care sector or in other sectors of the economy. The district court

provided petitioners with the opportunity to correct the Complaint's deficiencies after explaining its shortcomings, but petitioners failed to do so. Petitioners did not seek hearing or rehearing en banc in the Eighth Circuit.

The error in this case was not the Eighth Circuit's decision, but petitioners' failure to satisfy firmly established pleading requirements to plausibly allege a relevant market. The petition should be denied.

STATEMENT OF THE CASE

A. Background and Facts Relevant to the Petition

Because the Complaint was dismissed pursuant to Fed. R. Civ. P. 12(b)(6) for failure to allege a plausible relevant product market or relevant geographic market, the relevant facts are those alleged in the Complaint related to relevant market definition in antitrust cases.

Petitioners are seven cardiologists, their individual professional corporations, and Little Rock Cardiology Clinic, P.A., a cardiology practice through which the individual petitioners provide cardiology services (collectively LRCC). LRCC's initial complaint, filed in November 2006, named only the clinic as plaintiff and only Baptist Health as defendant. Shortly thereafter, LRCC filed an amended complaint adding the individual LRCC cardiologist-members and their

professional corporations as plaintiffs. LRCC amended its complaint again in December 2007, adding as defendants Arkansas Blue Cross & Blue Shield and USAble Corporation (a Blue Cross subsidiary) (collectively Blue Cross); Baptist Medical System HMO, Inc. (a Baptist Health subsidiary) (collectively Baptist Health); and HMO Partners, Inc. (a joint venture between Blue Cross and Baptist Health providing health-maintenance services).

Blue Cross and Baptist Health moved to dismiss the second amended complaint for failure to state a claim, arguing, among other things, that its product and geographic market definitions were fatally vague. The district court granted the motions from the bench after a February 2008 hearing but granted LRCC leave to amend its complaint.

LRCC filed its third amended complaint (which is the subject of its petition) in March 2008. Counts I through IV, the same claims as in the previous complaints, allege that Blue Cross and Baptist Health conspired to unreasonably restrain competition in a product market variously defined as services provided by cardiologists or a single product consisting of services provided by cardiologists and services provided by hospitals, in violation of Section 1 of the Sherman Act (Count I); and a conspiracy to monopolize (Count II), attempted monopolization (Count III), and monopolization (Count IV) of the same provider product market, in violation of Section 2 of the Sherman Act. Counts V through VII, which first appeared in this Complaint, allege violations affecting a market for

health insurance: a conspiracy between Blue Cross and Baptist Health to monopolize the "market for private insurance" in violation of Section 1 of the Sherman Act (Count V), attempted monopolization of that market by Blue Cross and Baptist Health (Count VI), and monopolization of that market by only Blue Cross (Count VII). A new Count VIII requests injunctive relief but alleges no new substantive violation.

The gravamen of the Complaint is the same as the previous three complaints: that in 1997, when the LRCC physicians (who had staff privileges at Baptist Health) invested in and built a single-specialty cardiac hospital that competed with Baptist Health, Blue Cross and Baptist Health retaliated by conspiring to terminate LRCC's participating status in Blue Cross's provider network (*e.g.*, Pet. App. at 129a, ¶ 132); and that six years later, in 2003, when Baptist Health learned that other physicians on its medical staff planned to invest in and build an orthopedic hospital, Blue Cross and Baptist Health conspired in Baptist Health's adoption of a policy preventing any physician who invested in a competing hospital from maintaining medical-staff privileges at Baptist Health, a policy that would affect the LRCC physicians because of their ownership interest in their cardiac hospital. *Id.* at 134a through 136a, ¶¶ 146-52. An Arkansas state court enjoined enforcement. *Id.* at 136a, ¶ 154.

LRCC's theory of antitrust injury is based on its 1997 termination from Blue Cross's network. According to the complaint, the termination and Blue

Cross's refusal to readmit LRCC to the Blue Cross network thereafter foreclosed the cardiologists from a substantial number of patients covered by private insurance and precluded them from competing for Blue Cross subscribers. Pet. App. at 82a, ¶ 13; 130a, ¶ 134; 134a, ¶ 145; 153a, ¶ 192; 155a, ¶ 198. LRCC also alleged that if the Baptist Health 2003 credentialing policy had not been enjoined, LRCC would have been precluded from providing cardiology services at Baptist Health. The defendants' intent, according to the Complaint, was to increase the market power of Blue Cross in the insurance market and Baptist Health in hospital services. *Id.* at 79a, ¶ 3.

The Complaint provides at least two definitions of the relevant product market. It first alleges that the product market is "those medical services that cardiology patients receive exclusively in a hospital from a cardiologist." Pet. App. at 85a, ¶ 22. In the next paragraph, the Complaint explains that the relevant product market is a single market consisting of a combination of both services provided by cardiologists and services provided by hospitals. *Id.* at ¶ 23.

Various paragraphs in the Complaint allege that the relevant product market does not include provision of cardiologist services or sales of the single product market of cardiologist services and hospital services to all patients, but only those services provided to patients covered by private insurance, excluding those services provided to patients with other sources of payment – e.g., public insurance such as Medicare and Medicaid. *E.g.*, Pet. App. at 86a, ¶ 27;

88a, ¶¶ 35, 36; 155a, ¶ 198. The alleged rationale for this distinction is that from the standpoint of patients, private insurance and other sources of payment, such as Medicare and Medicaid, are not reasonable substitutes. *Id.* at 87a, ¶ 32. The Complaint alleges that LRCC treats publicly insured patients but that the reimbursement paid by public insurance is lower than that paid by private insurance. *Id.* at 154a, ¶ 193.

The Complaint alleges that the relevant geographic market consists of Little Rock (Pet. App. at 89a, ¶ 39), based on allegations that Little Rock residents needing services overwhelmingly use providers in Little Rock rather than more distant providers (*id.* at 89a, ¶ 41; 90a, ¶ 42; 91a, ¶¶ 45-46) and that a majority of Arkansas cardiologists are located in Little Rock (*id.* at 92a, ¶ 49). The Complaint also alleges, however, that Little Rock providers "draw large numbers of patients" and "a large percentage of residents from around the state." *Id.*; 93a ¶¶ 49, 51.

The Complaint's antitrust theory and LRCC's alleged antitrust injury rest primarily on Blue Cross's 1997 termination of the LRCC physicians from the Blue Cross provider network and thus LRCC's alleged inability to compete for privately insured cardiology patients. Pet. App. at 134a, ¶ 145; 139a, ¶ 164; 153a, ¶ 192; 155a, ¶ 198 ("defendants have proximately caused antitrust injury to plaintiffs by excluding and restraining plaintiffs from competing for privately insured cardiology patients"). According to the

Complaint, 138 cardiologists practice in Arkansas, of whom 51 are located in Little Rock. *Id.* at 92a, ¶ 49.

B. Procedural History and Opinions Below

1. Blue Cross and Baptist Health moved to dismiss the second amended complaint (which did not include Counts V through VII alleging anti-competitive effects in an insurance market) on several grounds, including that the relevant product and geographic markets were alleged in fatally vague and conclusory fashion and that LRCC alleged no relevant product market in which it and either defendant were competitors.

At the February 2008 oral argument on these motions, LRCC acknowledged the need to plead and prove a relevant market, telling the district court that "this is not a per se situation, so the rule of reason . . . requires some kind of showing of effect or probable effect, and the only way that a court can evaluate that is in the context of a relevant market." Tr. of Feb. 27, 2008 Hearing at 41. About the relevant product market, LRCC argued both that the product market is (1) limited to services provided by cardiologists and (2) a "conjoined" single product market consisting of two economic complements – services provided by cardiologists and services provided by hospitals. LRCC agreed with the district court's statement that the product market had to be "services offered by cardiologists" (*id.* at 25) and that "the product market defined in the complaint is services offered by

cardiologists in hospitals" (*id.* at 43), but LRCC also told the district court that the product market is a market of "conjoined products" (*id.* at 24): "[T]he relevant product has two components. It has a physician component and a facilities component." *Id.* at 25-26.

At that hearing, LRCC claimed that the relevant geographic market was "central Arkansas." When the district court indicated that it did not know what area that encompassed, LRCC told the court that it did not know either. Tr. of Feb. 27, 2008 Hearing at 28.

At the argument's conclusion, the district court dismissed the second amended complaint from the bench, relying on *Bell Atl. Corp. v. Twombly*, 550 U.S. 544 (2007), but granted LRCC leave to amend. The district court explained that "the relevant product market has to be services offered by physicians, and that's what the complaint alleges and that's what the brief says, that these are services offered by cardiologists and no defendant is a cardiologist and no defendant competes in that market." Tr. of Feb. 27 Hearing at 57. The district court also held that the second amended complaint's allegations failed to provide the defendants with sufficient notice of the scope of a geographic market, which the Complaint delineated merely as central Arkansas.

2. LRCC filed its third amended complaint in March 2008; Blue Cross and Baptist Health again moved to dismiss for failure to state a claim. They argued that the statute of limitations barred all the claims, that the product- and geographic-market

claims remained unduly vague and unsupported, and that LRCC failed to allege any adverse effect on competition in the apparent relevant product market – provision of cardiologists' services.

At the August 2008 hearing on these motions, LRCC again acknowledged the necessity of pleading and proving a relevant market, explaining to the district court that "[t]he relevant market, as the Court is well aware, is an economic construct that is essential to antitrust analysis in order to measure anticompetitive effect." Tr. of Aug. 6, 2008 Hearing at 83. As to product-market definition, LRCC argued at one point that the product market included three components: "We have not only been consistent, but coherent in describing what is the product/service market, and it does consist of three elements, and it's hospital services and it is private insurance and it is cardiologist services. They are inevitably combined and integrated, conjoined; 'complements' describes it." *Id.* at 84. Later in the argument, LRCC agreed with the district court's statement that "[t]he reasoning I thought from the complaint, the third amended complaint and from the brief, was that because a cardiology patient . . . needs both a cardiologist and a hospital, therefore you treat them both in the same market. That's almost an exact quote from the complaint." *Id.* at 94.

3. Several weeks after oral argument on the motions, the district court dismissed the case as to all defendants. It held that Counts V through VII (those alleging a relevant product market of health

insurance) were barred as to all defendants by the statute of limitations, and that Counts I through IV (those alleging a provider relevant product market) were barred by the statute of limitations as to Blue Cross but not as to Baptist Health. As to Counts I through IV against Baptist Health, the district court held that LRCC's product- and geographic-market allegations were insufficient and that whether the product market that LRCC attempted to allege was a market of only cardiologists' services or the single conjoined market, the allegations were insufficient to support limiting the product market to services rendered to only privately insured patients.

The district court explained that the injury for which LRCC sought redress resulted from Blue Cross's refusal to deal – LRCC's exclusion from Blue Cross's provider network and thus its foreclosure from Blue Cross subscribers. Pet. App. at 33a. As to the relevant product market for Counts I through IV, the court held that they were "incoherent," resulting from an incurable defect in LRCC's legal theory. *Id.* at 25a. Because the district court could not discern whether LRCC was attempting to allege a product market of only cardiologists' services or a conjoined market of both hospital and cardiologists' services, it analyzed both possibilities. As to the former, it explained that neither Blue Cross nor Baptist Health were competitors in that market and so could not monopolize or attempt to monopolize it. *Id.* at 46a-47a. As to the Section 1 conspiracy claim (Count I), the district court explained that the complaint contained no allegations

of any unreasonably adverse effect in the market for cardiology services. *Id.* at 49a.

Turning to the other possible product market that LRCC might be attempting to allege – the conjoined services market – the district court rejected that market definition because the two types of services are complements, not substitutes. It explained that relevant product markets include only reasonable substitutes and that, as a matter of law, substitutes and complements are not in the same relevant product market. Quoting the leading antitrust treatise, the district court explained that "'[g]rouping complementary goods in the same market is . . . economic nonsense.'" Pet. App. at 54a (quoting IIB PHILLIP E. AREEDA, ET AL., ANTITRUST LAW ¶ 565a at 406 (3d ed. 2007)). The district court concluded that "as a matter of law, complementary products sold separately are not in the same product market." *Id.* at 60a.

The district court also held that regardless of which product market LRCC was attempting to allege, it could not be limited to services provided to privately insured patients. The court explained that given LRCC's theory of antitrust injury – "their exclusion from the [Blue Cross] network" (Pet. App. at 62a) – the product market must include "all persons who need cardiologists' services, not just that smaller group who are insured or reimbursed" (*id.* at 62a-63a) because "[t]o say that these cardiologists are foreclosed from the [Blue Cross] network says nothing

about the impact on competition among cardiologists" (*id.* at 63a).

As to the Complaint's allegations about the relevant geographic market, the district court accepted LRCC's factual allegations that most Little Rock residents needing cardiology services obtained those services in Little Rock, but concluded that this did not mean that Little Rock could be delineated as an appropriate relevant geographic market. Pet. App. at 68a. LRCC's allegations that a large percentage of the patients using Little Rock providers come from other areas of the state indicated that the geographic market was larger than Little Rock, and thus a Little Rock market was not plausible. *Id.* at 64a-68a. If the geographic market could be limited to any area in which few patients residing in that area left the area for services, without consideration of the alternatives available to patients residing outside that area who come into the area for services, LRCC could have equally selected any even smaller area where only a small percentage of patients leave the area for services. *Id.* at 69a. Accordingly, the district court dismissed all counts against all defendants.

4. LRCC appealed the district court's product market, geographic market, and statute of limitations holdings on Counts I through IV. It did not appeal the district court's dismissal of Counts V through VI (the claims alleging violations affecting an insurance market) as to all defendants, so no claims relating to an

insurance market remained in the case.[1] Pet. App. at 6a. In affirming the district court's decision, the Eighth Circuit agreed that the Complaint was fatally flawed for *each* of two independent reasons: It alleged *neither* a plausible relevant product market *nor* a plausible relevant geographic market.

The Eighth Circuit recognized the uncertainty of whether LRCC was attempting to allege a relevant product market of only the services of cardiologists or a conjoined product market of cardiologists' and hospital services, explaining that it was "unclear" what product market LRCC attempted to allege. Pet. App. at 8a. It chose, however, to affirm the district court's conclusion that whatever the provider product market encompassed, it could not be limited to services to privately insured patients. *Id.* at 8a.

The court explained that because of the nature of LRCC's alleged injury – its foreclosure from and inability to compete for particular patients – the proper inquiry must determine and include in the relevant product market all sources of patients available to LRCC. In a "shut-out supplier" case such as this, market definition is based on "to whom can the supplier sell?" Pet. App. at 10a. The Complaint's allegations showed that LRCC accepts both privately

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[1] LRCC and Blue Cross settled the case as to Blue Cross several days before oral argument in the Eighth Circuit. Blue Cross filed a brief in the appeal but did not participate in oral argument.

insured patients and those covered by public insurance programs such as Medicare and Medicaid. *Id.* at 10a. Given those allegations, the Eighth Circuit explained, the relevant product market could not, as a matter of law, be limited to services rendered only to privately insured patients. *Id.* at 10a-11a.

In reviewing the geographic market issue, the Eighth Circuit concurred with the district court that the Complaint's allegations failed to support a plausible geographic market limited to Little Rock, explaining that this flaw provided an independent ground for affirming the district court's decision. Pet. App. at 11a. It relied on the principle for defining geographic markets established in *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961), which requires assessing both where sellers operate and where purchasers can turn for the service in question. *Id.* To implement the analysis in this case, the court explained, "[t]he end goal . . . is to delineate a geographic area where 'few patients leave . . . and few patients enter.'" *Id.* at 11a (quoting *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1267 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990)).

The Eighth Circuit explained that the Complaint's support for a geographic market limited to Little Rock consisted merely of allegations that patients residing in Little Rock overwhelmingly patronize Little Rock providers for cardiology services. The Complaint, however, did not include allegations relating to the alternatives of patients residing in other areas of Arkansas, many of whom used Little

Rock providers. Absent allegations relating to the "inflow" of patients residing outside of Little Rock, an alleged geographic market limited to Little Rock is not plausible. Pet. App. at 13a. This first step – determining from where the providers' patients come – is essential, the court explained, because merely choosing an area in which a large percentage of residents use providers in that area can result in "arbitrarily narrow markets." *Id.* at 14a. Based on its methodology for defining geographic markets, LRCC could claim that the geographic market included only the block surrounding the provider if most of that block's residents used the provider in question. *Id.* The Eighth Circuit did not purport to prescribe or mandate any particular methodology that a party must use to define a geographic market. Instead, it held only that this Complaint's factual allegations could not sustain a plausible geographic market, given the methodology that LRCC chose to use.

The Eighth Circuit warned against reading its opinion as holding that a city could not constitute a relevant geographic market under different allegations, or that a relevant geographic market can never encompass an area smaller than a firm's trade or service area. Pet. App. at 14a, 16a. Rather, its conclusion that the Complaint failed to sufficiently allege a relevant geographic market was based on this Complaint's allegations. *Id.* at 17a. The Eighth Circuit dismissed the case without reaching the question whether the statute of limitations barred Counts I through IV against Baptist Health.

LRCC did not request panel rehearing or rehearing en banc.

REASONS FOR DENYING THE PETITION

I. LRCC FAILED TO RAISE ITS "DON'T-NEED-TO-DEFINE-THE-RELEVANT-MARKET" ARGUMENT BELOW, SO THAT ISSUE IS NOT PROPERLY BEFORE THIS COURT.

As one question presented for review, LRCC argues that it was not required to allege a relevant market because it claims that Baptist Health's conduct resulted in anticompetitive effects. Pet. at i. LRCC, however, did not raise this issue before either the district court or the Eighth Circuit in its briefs or oral arguments, so neither court considered it. Indeed, at both oral arguments before the district court, LRCC indicated that defining the relevant market is an essential element of its case.

Because LRCC raises this question for the first time in its petition, the issue is not properly before this Court, and this Court should not consider it. *United States v. United Foods, Inc.*, 533 U.S. 405, 417 (2001); *Delta Airlines, Inc. v. August*, 450 U.S. 346, 362 (1981).

II. IN HOLDING THAT THE COMPLAINT'S ALLEGATIONS FAIL TO SUFFICIENTLY SUPPORT LRCC'S ALLEGED RELEVANT MARKET, THE EIGHTH CIRCUIT APPLIED THE SAME MAINSTREAM ANTITRUST PRINCIPLES AS OTHER COURTS OF APPEALS, AND THE COURT APPLIED THOSE PRINCIPLES CORRECTLY.

The Eighth Circuit affirmed the district court judgment on two separate and independent grounds – LRCC's failure to provide adequate factual allegations to support both its alleged relevant product market and its relevant geographic market. Either shortcoming is fatal to the Complaint.

The premise of LRCC's petition and the briefs of *amici* is that the Eighth Circuit applied, or required LRCC to apply, incorrect methodologies to define both the relevant product market and relevant geographic market. LRCC and the American Medical Association also argue that the Eighth Circuit decided these questions as matters of law when they are issues of fact (Pet. at 13, 16, 27, 30), that the Eighth Circuit created "radical new approach[es]" (Pet. at 30) and "new substantive rules" (AMA Br. at 7) for defining relevant markets, and that the Eighth Circuit's market-definition analyses conflict with those of other circuit courts of appeals. The economists' *amicus* brief sweepingly asks this Court to reject the "patient-flow" methodology for defining relevant geographic markets, in light of academic papers criticizing that approach.

None of these arguments has merit. Whether a particular market-definition methodology is proper is a question of law, not fact. *E.g.*, *Worldwide Basketball & Sports Tours, Inc. v. NCAA*, 388 F.3d 955, 959, 960 (6th Cir. 2004). And although market definition is ultimately a question of fact, lower courts do not hesitate to grant Rule 12(b)(6) motions when plaintiffs fail to adequately support their alleged relevant markets with sufficient factual allegations. *E.g.*, *Campfield v. State Farm Mut. Auto. Ins. Co.*, 532 F.3d 1111, 1118 (10th Cir. 2008) (product market); *Apani Sw., Inc. v. Coca-Cola Enters., Inc.*, 300 F.3d 620 (5th Cir. 2002) (geographic market). The market definition principles applied by the Eighth Circuit are the same principles as those other courts of appeals have applied when faced with antitrust theories and allegations similar to those here. The Eighth Circuit correctly applied those principles to the specific allegations in the Complaint.

A. The Eighth Circuit's Holding That LRCC Failed To Allege A Plausible Relevant Product Market Applies The Same Mainstream Antitrust Principles As Other Courts Of Appeals Examining Similar Facts And Antitrust Theories, And The Court Applied Those Principles Correctly Here.

1. The appropriate methodologies for defining relevant product markets depend on the plaintiff's antitrust theory and the type of competitive injury it

alleges. LRCC's theory in this case is one of vertical foreclosure – that as a result of its termination by Blue Cross (a purchaser), LRCC (as a seller) was foreclosed from competing for Blue Cross or other privately insured patients. Pet. at 20. The potential antitrust concern in this situation is that a competitor of the excluded seller may obtain market power because of the seller's foreclosure from business. *See generally*, ABA SECTION OF ANTITRUST LAW, ANTITRUST HEALTH CARE HANDBOOK 257 (4th ed. 2010) (explaining that no anticompetitive effect is likely unless foreclosure of the plaintiff "permits the providers with whom the health plan contracts to obtain or maintain market power"). That might be possible if LRCC were foreclosed from a substantial share of all cardiology patients *and* if the market included few other competing cardiologists. The Complaint, however, alleges that even if the relevant geographic market were limited to Little Rock, that market would include at least 40 cardiologists in addition to LRCC, and there is no allegation that those cardiologists were foreclosed from the market. *Cf. Univac Dental Co. v. Dentsply Int'l, Inc.*, 2010-1 Trade Cas. (CCH) ¶ 76,998 at 117,032 (M.D. Pa. Mar. 31, 2010) (explaining that "[a] showing that the challenged practices bar a substantial number of rivals [from the market] . . . is required to demonstrate a § 2 antitrust violation") (internal quotation marks omitted).

2. Given the nature of LRCC's antitrust claims, the relevant product market cannot be limited to privately insured patients, excluding patients with other

sources of payment. Where the plaintiff's antitrust theory is based on vertical foreclosure, decisions from other circuits and leading commentary agree that the relevant product market includes all other potential sources of business to which the seller can turn, not merely some sub-group of potential business. *E.g.*, IIB PHILLIP E. AREEDA, ET AL., ANTITRUST LAW ¶ 570b1 at 418-19 (3d ed. 2007):

> The relevant market for this purpose includes the full range of selling opportunities reasonably open to rivals, namely all the product and geographic sales they may readily compete for, using easily convertible plants and marketing organizations. The foreclosure resulting from a vertical merger (or other arrangement) is thus measured in a market including the total output of the sellers who would be included in the market for assessing a horizontal merger between the merging seller and any other allegedly foreclosed rival.

Leading court of appeals decisions involving facts similar to those alleged here apply the same principle. In *Stop & Shop Supermarket Co. v. Blue Cross & Blue Shield*, 373 F.3d 57 (1st Cir. 2004), where a Blue Cross plan refused to admit the plaintiff, a pharmacy, to its provider network, court rejected, as a matter of law, the "shut-out supplier" plaintiff's argument that the relevant product market could be limited to sales of prescriptions to patients with insurance. 373 F.3d at 67. Rather, the court explained that the product market must include sales to all purchasers,

regardless of their source of payment because the plaintiff's alternatives to Blue Cross subscribers included "*all* retail customers for prescription drugs – not just that smaller sub-group who are insured or reimbursed. To say that some sub-group of customers is foreclosed proves nothing by itself about the impact on pharmacies." 373 F.3d at 66-67 (emphasis in original). In a case with similar facts, the Third Circuit reached the same conclusion in *Brokerage Concepts, Inc. v. U.S. Healthcare, Inc.*, 140 F.3d 494, 513-15 (3d Cir. 1998), and the Sixth Circuit approved the same analysis and result in *B&H Med., L.L.C. v. ABP Admin., Inc.*, 526 F.3d 257, 263 (6th Cir. 2008).[2]

3. Nor do any of the cases cited by LRCC support its argument that the Eighth Circuit erred in viewing the relevant product market as including all sources of patients rather than only privately insured patients. Pet. at 21-25. Product-market definition was not an issue and was not discussed in *Blue Shield v. McCready*, 457 U.S. 465 (1982), a decision involving

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[2] LRCC argues that in some situations, the price differential between two products may be sufficiently large that they are not in the same relevant product market (Pet. at 17), but the Complaint does not include any allegations plausibly showing that because reimbursement paid to physicians by public insurance programs is lower than that paid by private insurance, physicians would not turn to publicly insured patients if they lacked access to privately insured patients. In fact, as noted before, the Complaint alleges that LRCC provides services to publicly insured patients as well as to privately insured patients.

only antitrust standing and antitrust injury – issues arising under Section 4 of the Clayton Act, not under Section 1 or 2 of the Sherman Act. In *Blue Cross & Blue Shield v. Marshfield Clinic*, 65 F.3d 1406, 1410-11 (7th Cir. 1995), the court analyzed whether health-maintenance and preferred-provider health plans were in the same or separate product markets, and held that the product market included both. Whether the product market included, or could include, both privately insured patients and publicly insured patients was not raised by the parties or discussed in the opinion. Likewise, the question was not an issue and was not discussed by the court in *Reazin v. Blue Cross & Blue Shield*, 899 F.3d 951 (10th Cir. 1990), a case that examined antitrust standing and several other issues but did not consider or decide whether privately insured and publicly insured patients are in separate product markets.[3]

In sum, the Eighth Circuit's decisional principle of law is consistent with decisions in other circuits in

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[3] The American Medical Association's *amicus* brief focuses on issues that were not addressed by the Eighth Circuit or raised in the petition – monopsony power in the market for health insurance. AMA Br. at 9-12. The district court dismissed all the LRCC claims that were based on effects in the market for insurance (Counts V through VII) as barred by the statute of limitations. The Eighth Circuit did not review that issue, and the petition does not raise it. Moreover, the Complaint does not allege monopsonization, attempted monopsonization, or conspiracy to monopsonize.

similar cases. As those cases and leading commentary show, the decision is correct.

B. The Eighth Circuit's Separate Holding That LRCC Also Failed To Allege A Plausible Relevant Geographic Market Applies The Same Mainstream Antitrust Principles As Other Courts Of Appeals Analyzing Geographic Markets In Health-Care Antitrust Cases, And The Court Applied Those Principles Correctly.

As a second, independent ground for affirming the district court's judgment, the Eighth Circuit held, based on the Complaint's factual allegations, that LRCC's alleged relevant geographic market was not plausible.

1. The Eighth Circuit applied the principle for defining geographic markets enunciated in *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320 (1961) – that geographic market definition is a function of "the area in which the seller operates, and to which the purchaser can practicably turn for supplies." 365 U.S. at 327. Courts of appeals have applied this principle from the time of *Tampa Electric* to this day. *E.g.*, *Wampler v. Sw. Bell Tel. Co.*, 597 F.3d 741, 744 (5th Cir. 2010); *Mich. Div. – Monument Builders v. Mich. Cemetery Ass'n*, 524 F.3d 726, 733 (6th Cir. 2008). And the Eighth Circuit and other courts have not hesitated to dismiss complaints at the pleading stage for failing to adequately allege a relevant

geographic market. *E.g.*, *Double D Spotting Serv., Inc. v. Supervalu, Inc.*, 136 F.3d 554, 560 (8th Cir. 1998); *Michigan Division*, 525 F.3d at 733.

2. In cases involving markets for health-care providers, plaintiffs and courts have frequently relied, as the Complaint does here, on "patient-flow" data to establish geographic markets. *See*, *e.g.*, *Nilavar v. Mercy Health Sys.*, 244 Fed. App'x 690, 697 (6th Cir. 2007); Economists' Br. at 7 n.2 (citing cases). Under this methodology, if a small percentage of the patients using providers in an area come from outside the area (patient "inflow") and a small percentage of patients residing in the area use providers outside the area (patient "outflow"), the area may properly be deemed a relevant geographic market. *See FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1291-92 (W.D. Mich. 1996), *aff'd per curiam*, 121 F.3d 708 (6th Cir. 1997); Economists' Br. at 10.

Allegations of patient inflow and outflow are *both* necessary to define the geographic market using this methodology. *See*, *e.g.*, *Cal. v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1120 (N.D. Cal. 2001) (explaining that "[t]he first step" in determining the geographic market is to determine where patients come from – i.e., "[s]ervice area analysis"). Even if patients residing in the area are unwilling to procure services from providers outside the area (i.e., patient outflow is small), a provider could not profitably increase prices to those patients if a significant portion of the provider's patients come from outside the area (i.e., patient inflow is significant), and could

readily turn to providers outside of the putative geographic market. For that reason, a small amount of patient outflow, standing alone, is insufficient to support a plausible relevant geographic market.

3. The Eighth Circuit did not mandate that LRCC adopt a patient-flow methodology as a "black letter pleading requirement" as the briefs of the *amici* argue. AMA Br. at 15; Economists' Br. at 6. The decision to rely on patient-flow data to support its geographic market allegation was LRCC's choice alone. But having chosen to rely on that methodology, LRCC was required to allege patient-flow information sufficient to show that the geographic market was plausible. The Eighth Circuit held correctly that LRCC failed to do so.

The Complaint alleges that few residents of Little Rock leave Little Rock for cardiology services but, although it alleges that many patients come to Little Rock from around the state (Pet. App. at 93a, ¶¶ 49, 51), it provides no indication of the provider choices those patients have. LRCC correctly points out that an important variable in defining a geographic market is the area where patients may turn for alternative sources of care (Pet. at 29-30), but allegations relating to the area from which the provider draws patients are essential to identify those patients whose alternatives require examination. Alleging only patient outflow from an area that the plaintiff claims is a relevant geographic market, without alleging patient inflow, is akin to attempting to clap with one hand. *Twombly* requires factual allegations

sufficient to support each essential element of a plaintiff's claim; a Zen riddle is not enough.

Instead of including allegations relating to this first necessary step (*cf.* Economists' Br. at 20 ("LRCC did not produce an inflow statistic")), LRCC simply picked an area – Little Rock – where most of the residents use Little Rock providers. This, by itself, is not sufficient to allege a plausible relevant geographic market. *Cf. Nilavar*, 344 Fed. App'x at 697 (explaining that under this methodology, "plaintiff would have to show that few residents of his geographic market leave the area to obtain [the relevant service] *and that few patients residing outside of the [alleged] geographic market come to the area to obtain* [the relevant service]") (emphasis added). As both the district court and Eighth Circuit explain, LRCC's methodology and factual allegations permit it to pick an area as small as a block (or even smaller) around the provider's location and conclude that it is a relevant geographic market if a large percentage of that area's residents patronize the provider.

A small amount of patient outflow from Little Rock may be "consistent" with a relevant geographic market limited to Little Rock, but, standing alone, it does not "plausibly suggest[ ]" that Little Rock is a geographic market. *See Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 557 (2007). Absent other allegations, the alleged small amount of patient outflow is equally consistent with a significantly larger geographic market. Accordingly, just as in *Twombly*, where the "plaintiffs' assertion of an unlawful agreement was a

legal conclusion . . . not entitled to the assumption of truth" because it was supported only by allegations of parallel conduct, *Ashcroft v. Iqbal*, 129 S.Ct. 1937, 1950 (2009) (internal quotation marks omitted), so too here, LRCC's assertion that the geographic market can be limited to Little Rock is a legal conclusion that is not entitled to an assumption of truth because it is supported only by allegations of patient outflow.

4. The Eighth Circuit did not hold that a city cannot constitute a relevant geographic market as LRCC claims. Pet. at 12. Indeed, it emphasized the opposite, stating explicitly that its rejection of LRCC's alleged geographic market based on *this* Complaint's allegations "should not be read to reject the notion that a city by itself could, in a different case, be a relevant geographic market." Pet. App. at 14a. Nor did the Eighth Circuit hold that a firm's trade or service area is necessarily the relevant geographic market, even citing contrary authority. *Id.* at 16a. Rather, it held, based on the specific allegations of this Complaint, that the bare allegation that a large percentage of a provider's patients come from an area smaller than a provider's service area provides insufficient support for a claim that the relevant geographic market is smaller than the service area (*id.* at 17a), a proposition that is correct.

5. None of the decisions cited by LRCC conflict with the Eighth Circuit's rejection of LRCC's application of the patient-flow methodology to support its relevant geographic market. Pet. at 28-30. In *Hecht v. Pro-Football, Inc.*, 570 F.2d 982 (D.C. Cir. 1977), the court applied a straight-forward interpretation of the

Tampa Electric standard, as the Eighth Circuit did here, citing that decision as controlling authority. 570 F.2d at 988-89. *Hecht* noted that single cities can constitute relevant geographic markets, a possibility with which the Eighth Circuit agreed. And the issue in *Hecht*, unlike here, did not focus on the sufficiency of the complaint's geographic market allegations; the plaintiff had already jumped that hurdle.

In *Morales-Villalobos v. Garcia-Llorens*, 316 F.3d 51 (1st Cir. 2003), the court indicated that it was possible that the relevant geographic market could be as small as one region or could include other regions. But that decision does not discuss the complaint's specific allegations relating to the geographic market and, moreover, the case was decided prior to *Twombly* and thus under a different pleading standard.

The Sixth Circuit's decision in *City of Cleveland v. Cleveland Elec. Illuminating Co.*, 734 F.2d 1157 (6th Cir. 1984), rejected the argument that the geographic market included the defendant's service area absent actual or potential competition throughout that area. 734 F.2d at 1167. Again, the aptness of that decision for this case is not clear because the case was not decided based on the facts alleged in the complaint. In any event, the Eighth Circuit did not adopt a rule that geographic markets must coincide with a defendant's service area; it expressly stated the converse. The shortcoming of the Complaint is that although it alleges that a large percentage of the patients of Little Rock providers come from throughout the state,

it provides no insight into competition outside of Little Rock.

Thompson v. Metro. Multi-List, Inc., 934 F.2d 1566 (11th Cir. 1991), relies on the *Tampa Electric* principle as did the Eighth Circuit here. 934 F.2d at 1573. The court limited the geographic market to an area smaller than the City of Atlanta because it found that the plaintiff real estate agencies operated only in the smaller area, so multiple-listing services in other areas of the city were not reasonable substitutes and thus not in the same geographic market. *Id.* at 1573-74. The Complaint here, however, alleges that Little Rock providers serve not only Little Rock residents but patients throughout the state.

6. The Economists' Brief, based on little more than academic writings, urges this Court to reject a methodology for defining relevant geographic markets that it concedes federal courts have used "routinely in healthcare antitrust cases." Economists' Br. at 7. Far from constituting a "discredited geographic market analysis" (AMA Br. at 15), courts in almost every circuit analyzing relevant geographic markets involving health-care providers have approved and applied the patient-flow methodology that LRCC chose and the Eighth Circuit analyzed here. The Economists' Brief cites decisions from the Second, Sixth, Seventh, Eighth, and Ninth Circuits specifically employing the methodology. *Id.* n.2. Courts in the Third and Fifth Circuits have also approved the methodology or noted its use without objection. *See, e.g.*, *Gordon v. Lewistown Hosp.*, 272 F. Supp. 2d 393, 426

(M.D. Pa. 2003), *aff'd*, 423 F.3d 184 (3d Cir. 2005); *Surgical Care Ctr. v. Hosp. Serv. Dist. No. 1*, 2001 WL 8586 at *5-8 (E.D. La. Jan. 3, 2001), *aff'd*, 309 F.3d 836 (5th Cir. 2002).[4]

These authorities show that the methodology for defining geographic markets that LRCC chose and against which the Eighth Circuit measured the Complaint's allegations is not an inappropriate or unacceptable new substantive rule or "radical new approach" (Pet. Br. at 30) for defining geographic markets, but rather a mainstream methodology for defining markets in health-care antitrust cases. The Eighth Circuit, not to mention other courts, has applied it for at least the last 15 years or more. *E.g.*, *FTC v. Freeman Hosp.*, 69 F.3d 260, 264-65 (8th Cir. 1995); *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284-85 (7th Cir. 1990).

Moreover, the economists put forth no alternative approach and fail to suggest what facts a plaintiff must allege to support its market definition. And no lower courts have examined, analyzed, or applied

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[4] In its most recent challenge to a hospital merger, the Federal Trade Commission based its claim of a northern Virginia relevant geographic market on patient inflow and outflow data, alleging: "In 2006, for the hospitals located in Northern Virginia, approximately 90 percent of their patients came from Northern Virginia. Of the patients who reside in Northern Virginia, approximately 90 percent go to hospitals in Northern Virginia." Admin. Compl. ¶ 22, *Inova Health Sys. Found.*, FTC Dkt. No. 9326 (FTC May 9, 2008), *available at* http://www.ftc.gov/os/adjpro/d9326/080509admincomplaint.pdf.

other approaches or rejected patient-flow market definition methodologies. If the economists' criticism of patient-flow methodologies has any merit, the process of examining and testing other methodologies should begin in the lower courts, not here. And even if patient-flow analysis were an inapt methodology, dismissal would still have been appropriate because the Complaint provides no other grounds from which a relevant geographic market could be gleaned.

The American Medical Association merely provides hypothetical examples of situations in which it is *possible* that Little Rock could constitute a relevant geographic market under particular sets of facts that LRCC did not allege. AMA Br. at 16, 17-18. But it would not advance the development of the law for this Court to grant review in a case dismissed at the pleading stage just to consider various hypothetical possibilities; and in any event, "possibility" is short of the line of "plausibility." *Iqbal*, 129 S.Ct. at 1949-50; *Twombly*, 550 U.S. at 557. The Eighth Circuit merely held that this Complaint's allegations failed to cross the line from "possible" to "plausible." Its conclusion is correct.

III. NOTHING ABOUT THIS CASE PROVIDES IT WITH UNUSUAL IMPORTANCE.

LRCC and its *amici* offer various reasons of why this case supposedly has unusual importance: that the "decision will impose a significantly heightened pleading standard on antitrust plaintiffs" contrary to

Twombly (Pet. Br. at 10), although LRCC does not explain why this is so; that the decision will "insulat[e] from antitrust challenge highly concentrated insurance markets in which market and monopsony power predominate," thus undermining recent health-care reform legislation (AMA Br. at 9); and that the Eighth Circuit's "insistence that LRCC use a methodology that is inappropriate" requires correction by this Court (Economists' Br. at 21). None of these reasons withstand examination.

1. The Eighth Circuit's decision does not impose any heightened pleading standard. The court was fully cognizant of the appropriate pleading standard. Pet. App. at 6a. That standard requires plaintiffs to plead facts sufficient to show that their claims are plausible. Given the geographic market definition methodology that LRCC chose, the Complaint fails to address an essential variable – patient inflow into the alleged Little Rock market. Absent information about that variable, LRCC's factual allegations are insufficient.

2. The American Medical Association's concern focuses on allegedly "highly concentrated health insurance markets" (AMA Br. at 9), which are not germane to the issues on which LRCC seeks review. In any event, there is no reason to believe that the Eighth Circuit's decision will affect enforcement of the antitrust laws in markets for health insurance or permit health insurers to engage in monopsonistic conduct. Indeed, neither insurance markets nor allegations of monopsony are at issue here, and nothing in

the Eighth Circuit's opinion is contrary to previous interpretation and application of the antitrust laws in cases involving health-care sector industries.

The recently enacted health-reform legislation has no bearing on this case, which concerns only alleged conduct that predates that legislation. The American Medical Association's assertion that this legislation provides a reason to grant certiorari makes no sense. AMA Br. at 9. If the legislation has any relevance, it counsels in favor of denying the petition because the outcome and effects of the legislation are nebulous and amorphous at present. It is impossible to assess the different role, if any, of the antitrust laws in the health-care sector as a result of that legislation. Review of the issues raised in this case because of health-care reform would be most premature.

3. Regardless of how lower courts might react to the economists' criticism of patient-flow data in defining geographic markets, the Eighth Circuit did not insist that LRCC base its geographic market definition on patient flow. It merely reviewed the allegations that LRCC chose to make under the methodology that LRCC chose to use. The economists' criticism is more appropriately presented to the lower courts in future cases, where, with the benefit of further explication, evidence, and analysis, that criticism can be fairly and thoroughly assessed. There is no reason for that process to begin in this Court, on the almost non-existent record here.

CONCLUSION

The legal principles that the Eighth Circuit applied in reviewing the third amended complaint's product market and geographic market allegations are not in conflict with those applied by any other circuit examining similar facts or allegations. The Eighth Circuit applied those principles to the Complaint correctly. There is nothing about the case or the decision that provides it with more importance than numerous other antitrust cases in which health-care providers and insurers, or participants in other important sectors of the economy, are parties. Therefore, this Court should deny the petition for certiorari.

Respectfully submitted,

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